

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Busick 34720

State File No. 937

OCT 20 1952

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>937</u>	
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>ARKANSAS</u> b. COUNTY <u>Fulton</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>		c. LENGTH OF STAY (If in place) <u>5 HRS.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>MAMMOTH SPRINGS</u>		<u>80311</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BURGE HOSP.</u>				d. STREET ADDRESS (If rural, give location) <u>8</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>CAROLYN</u>		b. (Middle) <u>SUE</u>		c. (Last) <u>SMITH</u>	
4. DATE OF DEATH		(Month) <u>OCT.</u>		(Day) <u>16,</u>		(Year) <u>1952</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>MAY 12 1950</u>	
9. AGE (In years last birthday) <u>2</u>		10. UNDER 1 YEAR Months _____ Days _____		11. UNDER 1 MRS. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (City and State or Foreign Country) <u>THAYER, MISSOURI</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13a. FATHER'S NAME <u>JOHN H. SMITH</u>		13b. MOTHER'S MAIDEN NAME <u>MARGENE HOLDER</u>		14. NAME OF HUSBAND OR WIFE <u>X</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME <u>JOHN SMITH</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Meningitis Influenzal</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>1 d.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>481 X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-16</u> , 19 <u>52</u> , to <u>10-16</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>10-16</u> , 19 <u>52</u> , and that death occurred at <u>7:05</u> <u>am</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Urban J. Busick MD</u>				23b. ADDRESS <u>Springfield, Mo</u>		23c. DATE SIGNED <u>10-16-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>10-16-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>GOOD HOPE CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>PHILADELPHIA, MISSISSIPPI</u>	
DATE REC'D BY LOCAL REG. <u>10-16-52</u>		REGISTRAR'S SIGNATURE <u>Edith Williamson Registrar</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H.H. LOHMEYER</u>			
				ADDRESS <u>SPRINGFIELD, MO.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Walter E. Thumula

Licensed Embalmer No. *3898*

P. O. Address *Springfield, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.